Benefit Enrollment and Life Event Change Form

A

☐ Adding Dependent (check 1 below)	☐ Removing Dependent (check 1)	☐ New Enrollment (check 1)	Employer Name and Address: **State of New Hampshire 25 Capitol Street, Concord, NH 03301**

B

☐ Marriage ☐ Birth ☐ Legal Guardianship/Court Order ☐ Adoption	☐ Divorce/Legal Separation ☐ Death ☐ Access to Other Coverage ☐ Tier Change	☐ New Hire ☐ PT employee, benefit eligible ☐ Return from LOA ☐ RIF or Recall Placement	Employee Social Security # :	Union Affiliate ☐ SEA ☐ Trooper ☐ Unrepresented ☐ NEPBA 240 ☐ NEPBA 245 ☐ NEPBA 250 ☐ NEPBA 260 ☐ NEPBA 265 ☐ NEPBA 270

Employee Name (PLEASE PRINT), First, Last, MI	Employee Date of Birth:	Work Phone:

Address *(Street)* *(City)* *(State)* *(Zip Code)*

C

Last Name First Name M.I.	Add or Remove	Date of Birth	Gender	Coverage Selection	FSA Elections/Changes	PCP Choice for HMO Plan **(Use Anthem #)**	Existing Patient
Employee **SAME AS ABOVE**		**SAME AS ABOVE**	☐ M ☐ F	☐ Dental ☐ Medical ☐ HMO ☐ POS	☐ Medical $_____ / Year ☐ Waive Medical ☐ Dependent $_____ Year ☐ Waive Dependent		☐ Yes ☐ No
Spouse/Same Gender Spouse **Relationship** ☐ Spouse ☐ Same Gender Spouse Name: _____ Spouse/Same Gender Spouse SSN: _____ - _____ - _____	☐ Add ☐ Remove		☐ M ☐ F	☐ Dental ☐ Medical ☐ HMO ☐ POS			☐ Yes ☐ No
Dependent **Relationship** ☐ Employee's Dependent ☐ Dependent of Same Gender Spouse Dependent Name: _____ Dependent SSN: _____ - _____ - _____	☐ Add ☐ Remove		☐ M ☐ F	☐ Dental ☐ Medical ☐ HMO ☐ POS			☐ Yes ☐ No
Dependent **Relationship** ☐ Employee's Dependent ☐ Dependent of Same Gender Spouse Dependent Name: _____ Dependent SSN: _____ - _____ - _____	☐ Add ☐ Remove		☐ M ☐ F	☐ Dental ☐ Medical ☐ HMO ☐ POS			☐ Yes ☐ No

D

Employee's Signature / Date *The information provided above is true and correct to the best of my knowledge*. I also understand that the dependent coverage will not be effective until I provide appropriate documentation to my agency Human Resource office.

_____ Date: _____/_____/_____ Please make a copy for your personal records.

For Agency HR Use Only	**Agency**	**HR Representative Name**	**Contact #**	**Date Sent to DOP**	**Coverage Effective Date**
Payroll #: _ _ _ _					